

TYPHOID FEVER SURVEILLANCE REPORT

CDC NO.:
(1-5)

Form Approved OMB No. 0920-0009

Instructions:

– Please complete this form only for new, symptomatic, culture-proven cases of typhoid fever. –

DEMOGRAPHIC DATA

1. Reporting State: <input type="text"/> <input type="text"/> (6-7)	2. First three letters of patient's last name: <input type="text"/> <input type="text"/> <input type="text"/> (8-10)	3. Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> Mo. <input type="text"/> <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> <input type="text"/> Yr. (11-16) or Age: (in years) <input type="text"/> <input type="text"/> (17-18)
4. Sex: (19) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	5. Does the patient work as a foodhandler? (20) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	6. Citizenship: (21) 1 <input type="checkbox"/> U.S. 8 <input type="checkbox"/> Other: _____ 9 <input type="checkbox"/> Unk.

CLINICAL DATA

7. Was the patient ill with typhoid fever? (fever, abdominal pain, headache, etc) (22) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, give date of onset of symptoms: <input type="text"/> <input type="text"/> <input type="text"/> Mo. <input type="text"/> <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> <input type="text"/> Yr. (23-28)	8. Was the patient hospitalized? (29) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, how many days was the patient hospitalized? <input type="text"/> <input type="text"/> Days (30-31)	9. Outcome of case: (32) 1 <input type="checkbox"/> Recovered 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unk.
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LABORATORY DATA

10. Date <i>Salmonella typhi</i> first isolated: <input type="text"/> <input type="text"/> <input type="text"/> Mo. <input type="text"/> <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> <input type="text"/> Yr. (33-38)	Site(s) of isolation: (check all that apply) (39) 1 <input type="checkbox"/> Blood 2 <input type="checkbox"/> Stool 3 <input type="checkbox"/> Gall bladder 8 <input type="checkbox"/> Other (specify): _____ (40-55)
11. Was antibiotic sensitivity testing performed on this (these) isolate(s) at the laboratory? (Please contact the clinical laboratory for this information) (56) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	
If Yes, was the organism resistant to: <ul style="list-style-type: none">Ampicillin:(57) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not testedChloramphenicol:(58) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not testedTrimethoprim-sulfamethoxazole:(59) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not testedFluoroquinolones (e.g., Ciprofloxacin):(60) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not tested	

EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? (two or more cases of typhoid fever associated by time and place) (61) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	
13. Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness? (62) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, indicate type of vaccine received: <ul style="list-style-type: none">Standard killed typhoid shot (Wyeth-Ayerst):(63) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. Year received: <input type="text"/><input type="text"/> (64-65)Oral Ty21a or Vivotif (Berna) four pill series:(66) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (67-68)ViCPS or Typhim Vi shot (Pasteur Merieux):(69) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (70-71)
14. Did the patient travel or live outside the United States during the 30 days before the illness began? (72) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States) 1. _____ (73-88) 2. _____ (89-104) 3. _____ (105-120) 4. _____ (121-136) Date of most recent return or entry to the United States: <input type="text"/> <input type="text"/> <input type="text"/> Mo. <input type="text"/> <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> <input type="text"/> Yr. (137-142)
15. Was the purpose of the international travel: a.) Business?(143) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. b.) Tourism?(144) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. c.) Visiting relatives or friends?(145) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. d.) Immigration to U.S.?(146) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. e.) Other?(147) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (if other, specify): _____ (148-164)	
16. Was the case traced to a typhoid carrier?(165) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. If Yes, was the carrier previously known to the health department? (166) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	
17. Comments: _____ _____	

18. Name of Person Completing Form: _____ Address: _____ Telephone: (_____) _____ Date: _____ Mo. _____ Day _____ Yr. _____
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– THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM –

Please send a copy to your STATE EPIDEMIOLOGY OFFICE **and** the
FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION,
Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205

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